Patient Intake Form

General Information – Appointment Date: _____

Patient Name: (Circle one Mr./Mrs./Ms./Dr.) _____
First Mid. Int. Last Suffix

Preferred Name: _____ Gender: (Circle one) Male Female

Date of Birth: _____/____/_____ Preferred Language: _____

Address: _____
Street # Apt. #

City: _____State/Province: _____ Zip: _____

Cell Phone #: _____ Home Phone #: _____

Email Address: _____

How would you like to be contacted? (Circle all that apply) Phone Email Mail

Who referred you today? (Check one) ☐ Physician ☐ Patient ☐ Magazine

☐ Mailer ☐ Google ☐ WBAP ☐ Insurance ☐ Retirement Community

Name of Referral (if Applicable)? _____

Employment status (Circle one) Working Retired Other: _____

Employer: _____ Occupation: _____

Marital Status: (Circle one) Single Married Divorced Partner Widow Other

Spouse Name: _____ Is the Spouse a Patient? (Circle one) Yes No
First Mid. Int. Last

Emergency Contact

Name: _____ Relationship to Patient? _____
First Mid. Int. Last

Address: _____
Street # Apt. #

City: _____State/Province: _____ Zip: _____

Phone #: _____ E-mail Address: _____

Primary Physician

Name: _____ Phone #: _____

Please fill out both pages

Patient Intake Form

Release of Medical Information

Which of the following is your Main Concern:

☐ Hearing Loss With which ear do you hear best? (Circle one) Left Right

☐ Difficulty Hearing ☐ In quiet ☐ In Noise ☐ Tinnitus/ringing in ears ☐ Dizziness

For how long have you noticed difficulty hearing? _____

Have you been exposed to loud noise, either recently or in the past? (Circle one) Yes No

Have you seen an Ear, Nose, & Throat Physician (ENT)? (Circle one) Yes No

(Skip if not applicable) When was your last visit? _____ Physician's name? _____

Have you ever had surgery that may have affected your hearing? (Circle one) Yes No

Have you ever had an ear infection? ☐ As a child ☐ As an adult (Circle one) Yes No

Is there a history of hearing loss in your family? (Circle one) Yes No

Do you take Aspirin or any other blood thinners? (Circle one) Yes No

Do you take any prescription medications on a regular basis? (Circle one) Yes No

If so: Name of medication(s) _____ How Often? _____

Please check any of the following that you currently have or have had in the past:

☐ High blood pressure ☐ Head Injury ☐ Bell's Palsy ☐ Heart Trouble ☐ Meningitis ☐ Cancer

☐ Pacemaker ☐ Diabetes ☐ Radiation ☐ Measles ☐ Parkinson's ☐ Chemotherapy

Have you had a fall or near fall in the past year? (Circle one) Yes No

Rate your hearing on a scale from 1 to 10? (1 being poor, 10 being excellent) _____

In what situation would you or others say you have difficulty hearing? _____

What is your primary goal for today's visit?_____

If you are currently a hearing aid user, or have in the past, please answer the following:

How long have you used hearing aid/s? _____ Which ear was aided? (Circle one) Left Right

What would you improve about your current aid? _____

Release of Medical Information

I, _____, herby authorize Carson Hearing Care, PLLC, to release all medical information in the course of my (or my child's) treatment to (Please Check all that apply)

☐ Primary care physician ☐ Spouse ☐ Children ☐ Caretaker ☐ Nursing Facility

I have been given the opportunity to read or obtain a copy of the Notice of Privacy.

Signature: _____ Date:_____